DMI INSURANCE SERVICES, INC.
Automotive Program Specialists
www.dmi-insurance.com

PHYSICIAN'S STATEMENT

NAMED INSURED: _____ **EXAMINATION DATE** _____

Patient's Name:	DOB:	Age:	Sex:
Physician's Name:		Years Under Physician's Care:	
Physicians Address:			

On _____, I examined _____ to determine the individual's mental and physical fitness to operate a motor vehicle. My findings are as follows:

GENERAL HEALTH

Is there any nervous, organic, or functional disease which has advanced, or is likely to advance, during the next 12 months to a degree that will interfere with safe driving? ..... ☐ Yes ☐ No

If yes, explain: _____

MENTAL CONDITION

Is individual's alertness and mental activity adequate to cope with emergencies frequently found in driving? ..... ☐ Yes ☐ No

If no, explain: _____

PHYSICAL CONDITION

Has individual lost any of the following members: fingers, hand, arm, foot or leg? ..... ☐ Yes ☐ No

If yes, indicate the member(s): _____

Is there any partial or total loss of use of any of the above members that impairs safe driving ability? ..... ☐ Yes ☐ No

If yes, explain: _____

Has patient ever had any difficulty with the following:

Dizziness or fainting? ..... ☐ Yes ☐ No

Physical Reflexes? ..... ☐ Yes ☐ No

If yes, will the ailment currently affect the driver in normal operation of an automobile? ..... ☐ Yes ☐ No

If yes, explain: _____

Has he or she ever had any cardiovascular disease, heart attack or heart condition? ..... ☐ Yes ☐ No

If yes, explain: _____

When was the date of the first attack? _____

When was the date of the last attack? _____

Latest EKG ☐ Excellent ☐ Satisfactory ☐ Unsatisfactory

HEARING

Can individual hear ordinary conversation without a hearing aid? ..... ☐ Yes ☐ No

If no, does he/she wear a hearing aid? ..... ☐ Yes ☐ No

VISION

Has individual lost the use of either eye? ..... ☐ Yes ☐ No

Is there any opacity of the crystalline lens of either or both eyes? ..... ☐ Yes ☐ No

Can the individual distinguish red and green colors? ..... ☐ Yes ☐ No

Visual Acuity: Right Eye 20/_____ Left Eye 20/_____ Both Eyes 20/_____

Are the above visual acuity ratings with natural vision or with corrective glasses? ..... ☐ Yes ☐ No

REMARKS

EXAMINING PHYSICIAN'S SIGNATURE _____ DATE _____